Sentinel BENEFITS

Commonwealth of Massachusetts
Health Care/Dependent Care
Participant Termination/Unpaid Leave of Absence Form

Date:

Total Pages:_____page, including this cover page

Attention of: **Sentinel Benefits DCAP/HCSA Administrator**
Facsimile: **(781) 213-7301**
Telephone: **(781) 246-9050**

Name of Payroll Coordinator:
Telephone:
Facsimile:
E-Mail:

Agency Name:_____

Dept ID:_____

Name of Employee:_____

Check Appropriate Event: **Termination** _____

Unpaid Leave of Absence _____
(FMLA, Medical, NOP, etc.)

Date of Termination or Unpaid Leave of Absence:_____/_____/_____

Pay Check Date of Last DCAP and/or HCSA deduction:_____/_____/_____

Signature of Payroll Coordinator:_____

Additional Comments:

- **Keep the original in the employee's personnel file; fax a copy to the DCAP/HCSA Administrator.**
- **The employee will be terminated from the DCAP/HCSA plan upon receipt of this form by the Administrator.**
- **The Payroll Coordinator must inactivate the DCAP/HCSA deductions in the payroll system.**